STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	01/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey Survey Dates: December 27, 28, 29, 30, 2011, January 3, 4, 2012 Facility Number: 012448 Provider Number: 155785 AIM Number: N/A Surveyor Team: Diane Hancock, RN TC Vickie Ellis, RN Barbara Fowler, RN Amy Wininger, RN 1/3, 1/4/2012 Census Bed Type: SNF: 29 Residential: 54 Total: 83 Census Payer Type: Medicare: 18 Other: 65 Total: 83 Sample: 10 Residential sample: 7 These deficiencies also reflect state	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings in accordance with 410 IAC 16.2. Quality review completed on January 9, 2012 by Bev Faulkner, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure turning and repositioning and transfers were completed in accordance with each resident's written plan of care, for 1 of 4 residents reviewed for turning, repositioning, and transferring in the sample of 10. (Resident #12) Findings include: On 12/28/11 at 9:20 a.m., Resident #12 was observed sitting up in bed, eyes closed, and breakfast in front of him. He was observed on his back with head elevated 90 degrees. On 12/28/12 at 12:00 p.m., Resident #12 was observed sitting in his room in his wheelchair, and his lunch tray was delivered. On 12/28/11 an observation at 3:20 p.m. was made of Resident #12, sitting in his	F0282	F282Resident #12 suffered no ill effects from the alleged deficiency. Completion Date 2-03-12All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure implementation of the plan of care.Completion Date 2-03-12The C.N.A. that completed the care and did not follow the care plan was counseled on not following the plan of care concerning transfers. An in service was completed with the C.N.A.'s concerning the importance of following the plan of care. Systemic change is the C.N.A. will sign their assignment sheets at the end of their shift as an affirmation that the assigned care for their assigned residents was completed per the plan of care.Completion Date 2-03-12Nurse managers will perform random audits of C.N.A. care to assure plan of care is followed on 3 random residents 5 x week x one month 3 x a week x	02/03/2012

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	wheelchair in his room with his lunch tray in front of him. Resident #12 indicated he wished to be put back in bed. An observation was made at 3:30 p.m., of Resident #12 being put back to bed by Certified Nurse Aides #1[CNA] and CNA #2 . A transfer of Resident #12 was made with assist of 2. A gait belt was used and the resident was grasped underneath his armpits. After Resident #12 was in bed, an observation of a saturated incontinent adult brief was made. CNA #1 and CNA #2 wiped Resident #12 with incontinent wipes and reapplied a new brief. CNA #1 and CNA #2 positioned Resident #12 on his back, the call light within reach, and left Resident #12's room. An interview on 12/28/11 with RN #2, at 3:45 p.m., on 12/28/11, indicated Resident #12 was to be turned every 2 hours and off his butt as much as possible. An interview, on 12/29/11 at 3:05 p.m., with CNA #1, indicated he always used a gait belt and underarm transfer for Resident #12, because Resident #12 preferred it that way. CNA #1 also indicated using a sit to stand lift to transfer Resident #12 and depended on who was transferring Resident #12.		one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 2-03-12	

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	The clinical record of Resident #12 was reviewed on 12/27/11 at 2:50 p.m. A care plan, dated 8/25/11, indicated Resident #12 was to be checked for incontinence approximately every 2 hours and as needed. Further review of the care plan, dated 8/25/11, indicated Resident #12 was to be turned and repositioned every 2 hours. The care plan also indicated a mechanical lift was to be used when transferring Resident #12. On 12/29/11 at 3:30, CNA #1 provided a CNA assignment sheet which indicated a sit to stand lift was to be utilized when transferring Resident #12. On 1/4/12 at 10:05 a.m., the Director of Nursing [DoN] provided a document titled Interdisciplinary Team Care Plan Guideline which indicated the nurse managers will communicate care plan approaches through the nurse aid assignment sheet. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to provide on-going monitoring of the respiratory status of 1 of 4 residents reviewed for respiratory issues, in the sample of 10, in that the resident presented in the evening with shortness of breath and low grade temperature and no follow-up was noted throughout the night. (Resident #23) Finding includes: During interview of Resident #23 on 12/30/11 at 11:50 a.m., he indicated he had difficulty breathing and was coughing and expectorating large amounts of thick yellow mucous. Resident #23 was observed to have oxygen on at that time and indicated that he had become short of breath the evening before at approximately 6:30 p.m. Resident #23 indicated that his physician had been notified on 12/29/11 at 6:45 p.m., and a chest x-ray and blood work was ordered	F0309	F 309Resident #23 suffered no ill effects from the alleged deficiency.Completion Date 2-03-12All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure each resident receives necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care.Completion Date 2-03-12Nursing staff have been in serviced concerning documentation of condition changes. Systemic change is implementation of alert charting checklist.Completion Date 2-03-12DHS/Designee will perform audits of alert charting checklist to assure nurses completing timely documentation of assessments when a change of condition occurs on 3 random residents 5 x week on one month 3 x week x one month then weekly with results forwarded to	02/03/2012

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	which was to be done on 12/30/11. Resident #23 indicated the chest x-ray and blood work were obtained at 9:00 a.m. on 12/30/11. The clinical record was reviewed on 12/30/11 at 12:30 p.m. The resident's diagnosis list included, but was not limited to, congestive heart failure. The record review on 12/30/11 at 12:30 p.m., did not include follow-up documentation of his respiratory problem after 12/29/11 at 8:00 p.m. Upon interview of RN #1 on 12/30/11 at 12:40 p.m., the RN indicated that Resident #23's chest x-ray results were back and that Resident #23's physician had been notified but that the blood test results had not been received. The Minimum Data Set Coordinator indicated on 12/30/11 at 12:30 p.m., there was no other charting for Resident #23 since 12/29/11 at 8:00 PM. 3.1-37(a)		QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 2-03-12	
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			

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	Based on observation, record review and interview, the facility failed to ensure residents received showers or baths as scheduled for 3 of 8 residents who required assistance with bathing in the sample of 10. (Residents #23, #18, #1) Findings include: 1. During interview of Resident #23 on 12/27/2011 at 12:30 p.m., Resident #23 indicated that he had not been receiving showers as ordered. Resident #23 indicated that he was to receive showers at 5:00 a.m., but had not received a shower for quite some time. The clinical record of Resident #23 was reviewed on 12/29/11 at 10:50 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and bilateral below the knee amputations. It was indicated on the "Shower Schedule" that Resident #23 was to receive a shower during the day shift every Tuesday and Friday. It was indicated on the "ADL [Activities of Daily Living] Detail Report" that the resident had not received a shower from 12/15/11 through 12/28/11.	F0312	F 312Resident #23 and #6 suffered no ill effects from the alleged deficiency and were interviewed to determine the type of bathing desired and plan of care updated.Resident #1 no longer resides in the campus.Completion Date 2-03-12All residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and in servicing will prevent the recurrenc of the deficient practice.Completion Date 2-03-12All nursing staff have been in serviced on the bath schedule and documentation required. Systemic change is upon completion of a bath the nursing employee will complete documentation and forward it to the nurse to assure all baths completed in a timely manner.Completion Date 2-03-12DHS/Designee will monitor compliance with a tickler system to assure baths completed per assisgnment every week. Results of compliance audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 2-03-12	02/03/2012

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During the interview of CNA #6 on 12/29/11 at 12:25 p.m., CNA #6 indicated that Resident #23 did not receive a shower on 12/27/11. Also during an interview with CNA #7 at the same time, CNA #7 indicated Resident #23 received his shower on the night shift.

2. Resident #18's clinical record was reviewed on 12/28/11 at 11:10 a.m. The resident was admitted to the facility on 11/28/11 with diagnoses including, but not limited to, fractured right superior and inferior pubic ramus, ataxia, and a history of prostate cancer. The resident's initial Minimum Data Set assessment, dated 12/5/11, indicated he required total assistance of one person for bathing.

A family member indicated, on 12/27/11 10:20 a.m., the resident had worn the same clothes for 3 days. The family member indicated the resident had not had a bath in a couple weeks that she knew of.

Review of the bathing records for December, 2011, provided by the DNS [Director of Nursing Service] on 1/4/12 at 10:05 a.m., indicated the only showers provided were on 12/30 and 12/31/11. No bed baths were documented either, from

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	12/10 to 12/13/11 and from 12/26 to 12/29/11. There was no indication the resident had refused to take showers or receive bed baths. 3. Resident #1 was observed to receive a bed bath by QMA [Qualified Medication Aide] #1 on 12/30/11 at 9:30 a.m. The resident was observed to be incontinent of a large amount of watery loose stool. The resident was interviewed at that time and indicated she had not received any showers during her stay in the facility. The resident's record was reviewed on 12/29/11 at 12:05 p.m. The resident was admitted to the facility on 12/12/11 with diagnoses including, but not limited to, cancer, dysphagia, and Clostridium Difficile infection. The resident's Minimum Data Set assessment, dated 12/19/11, indicated she required total assistance of two persons for bathing. Review of the resident bathing records for December, 2011, provided by the Director of Nursing Services on 1/4/12 at 10:05 a.m., indicated the resident had not received a shower during the month of December. No bed baths were documented from the 12/12/11 admission to 12/18/11. The resident's record			

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	indicated she had on-going problems with diarrhea. There was no indication the resident refused showers or bed baths. 3.1-28(a)(2)(A)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to provide the services of repositioning and checking for incontinence to promote healing and to prevent future pressure ulcers for 1 of 4 residents reviewed for pressure sores in the total sample of 10. (Resident #12) Findings include: On 12/28/11 at 9:20 a.m., Resident #12	F0314	F 314Resident #12's pressure ulcer has healed and nursing staff have been in serviced on his plan of care to prevent pressure ulcers.Completion Date 2-03-12All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing nursing staff will ensure measures to prevent the development of pressure sores.Completion Date 2-03-12Nursing staff have been in	02/03/2012

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	was observed sitting up in bed, eyes closed, and breakfast in front of him. He was observed on his back with head elevated 90 degrees. On 12/28/11 at 10:25 a.m., RN #1 was observed doing a dressing change and treatment to Resident #12's left buttock area. A pressure ulcer was observed to be an open area reddened around the edges, 1 centimeter [cm] in diameter. RN #1 cleaned the area with wound cleanser and applied a 4 x 4 medicated pad to the wound. RN #1 and a hospice employee transferred Resident #12 into his wheelchair. On 12/28/11 at 12:00 p.m., Resident #12 was observed sitting in his room in his wheelchair, and his lunch tray was delivered. On 12/28/11 at 1:45 p.m., Resident #12 was observed sitting in his room in his wheelchair with a lunch tray in front of him. On 12/28/11, an observation at 3:20 p.m. was made of Resident #12 sitting in his wheelchair in his room with his lunch tray in front of him. Resident #12 indicated he wished to be put back in bed. An observation was made at 3:30 p.m. on		serviced on pressure ulcer prevention. Systemic change is current nursing staff will complete a return demonstration for turning and repositioning a resident at risk for pressure ulcers now and annually thereafter.Completion Date 2-03-12DHS/Desginee will perform random audits of C.N.A care to assure following standards of care to prevent ulcers on 3 random residents 5 x week x one month 3 x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 2-03-12	

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	12/28/11 of Resident #12 being put back to bed by Certified Nurse Aides #1[CNA] and CNA #2 . A transfer of Resident #12 was made with assist of 2. A gait belt was used and resident was grasped underneath his armpits. After Resident #12 was in bed, an observation of a saturated incontinent adult brief was made. CNA #1 and CNA #2 wiped Resident #12 with incontinent wipes and reapplied a new brief. CNA #1 and CNA #2 positioned Resident #12 on his back, the call light within reach, and left Resident #12's room. An interview on 12/28/11 at 3:45 p.m., with RN #2, indicated Resident #12 was to be turned every 2 hours and off his butt as much as possible. The clinical record of Resident #12 was reviewed on 12/27/11 at 2:50 p.m. A care plan, dated 8/25/11, indicated the resident was to be checked and changed approximately every two hours and as needed. The plan indicated a barrier cream was to be used. A signed physician's order of 8/12/11 indicated Resident #12 was to be turned and repositioned every two hours and to avoid positioning on buttock. A Skin Impairment Circumstance Assessment and Intervention form, dated			

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	12/19/11, indicated a "Stage 2" [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough] pressure ulcer to left buttocks on Resident #12. A Nursing Note, dated 12/19/11 at 1:40 p.m., noted an open area measuring 1.1 centimeters [cm] in length x 0.4 cm in width by < 0.1 cm in depth to left upper buttocks. On 1/4/12 at 10:05 a.m., a document titled "Wound Plan of Care Guidelines" indicated its purpose was to "provide individualized care interventions to treat areas of skin impairment and contributory causes." 3.1-40(a)(2)			
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			

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	Based on record review and interview, the facility failed to ensure the physician was notified of a significant change in weight, for 1 of 2 residents reviewed for weight loss in the sample of 7, in that the resident lost significant weight on more than one occasion and the physician was not notified. (Resident #82) Finding includes: The clinical record of Resident # 82 was reviewed on 1/3/12 at 1:00 p.m. Resident #82 was noted to have a weight loss on 10/2/11 of 6.8 pounds for the month. The physician was not notified until 10/14/11. On 10/17/11, the resident was re-weighed and found to have lost another 2.4 pounds and the physician was not notified. On 11/3/11, Resident #82 had a weight loss of 5.6 pounds for the month and the physician was notified on 11/7/11. On 12/4/11, Resident #82 had a weight loss of 6.6 pounds for the month. On 12/7/11 at 12:08 p.m., it was noted in the "Nurse's Notes" that Resident #82 was having trouble chewing and S.T. [speech therapy] was requested to do a screening which was completed on 12/8/11. On 12/9/11, Resident #82 received an order for a puree diet with thin liquids per	R0036	R 036Res #82's physician and family have been updated on her current weight and the RD has reviewed her plan of care.Completion Date 2-03-12All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus immediately consults the resident's physician and the resident's legal representative when the campus has noticed a significant decline in the resident's physical, mental or psychosocial status.Completion Date 2-03-12Nursing staff will be in serviced on the guidelines for weights and notification. Systemic change will be a new weight notification form.Completion Date 2-03-12DHS/Designee will monitor to assure resident's with significant weight changes have notification complete to physician timely on 2 random resident's daily x 5 days, 3 x week for 2 weeks, then weekly with results of compliance being forwarded to QA committee monthly x 6 months for review and further suggestions/comments.Completio n Date 2-03-12	02/03/2012

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	155785	A. BUILDING 00 B. WING	01/04/2012

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	S.T.'s recommendation. On 12/23/11, Speech Therapy indicated that Resident #82 was "tolerating pureed diet without difficulty" and that Resident #82 "may require thickened liquids in the future." On 12/30/11 at 8:40 a.m., an "Assisted Living Nutrition Assessment and Data Collection" was done on Resident #82 by the RD [Registered Dietician]. On 12/31/11, the physician was notified and orders received for weight loss measures to be started. LPN #2 was interviewed on 1/4/12 at 11:00 a.m. She indicated the resident had been losing weight; Speech Therapy was seeing her and she thought she was eating better.			

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R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of 1 staff with certification in CPR and First Aid was present, for 17 of 27 shifts reviewed. (12/18 evening, 12/19 evening/nights, 12/20 evening/nights, 12/21 evening/nights, 12/22 evening/nights, 12/23 evening/nights, 12/24 evening/nights, 12/25 evening/nights, 12/26 evening/nights) Finding includes:	R0117	R 117No residents suffered ill effects fom the alleged deficient practice.Completion Date 2-03-12All residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and in servicing will prevent the recurrence of the deficient practice.Completion Date 2-03-12In services were completed for nursing staff for CPR and First Aid. Systemic change includes on the daily work assignment it is designated who on the shift is certified for CPR and First Aid.Completion Date	02/03/2012

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	CPR and First Aid certifications were provided by the Assistant Director of Nursing Services on 1/3/12 at 3:30 p.m., and reviewed at that time. There were no staff members certified in First Aid. Only three staff members (LPN #1, LPN #2, CNA #5) were certified in CPR. The nursing schedule was provided by the Director of Nursing Services on 12/27/11 at 12:30 p.m. It was reviewed for employees certified in CPR/First Aid on 1/3/12 at 3:30 p.m. The following shifts did not have any staff present who were certified in CPR and/or First Aid: 12/18/11 evening shift 12/19/11 evening and night shifts 12/20/11 evening and night shifts 12/21/11 evening and night shifts 12/22/11 evening and night shifts 12/23/11 evening and night shifts 12/24/11 evening and night shifts 12/25/11 evening and night shifts 12/26/11 evening and night shifts On 1/3/12 at 3:50 p.m., the Administrator indicated they had classes in the previous year, but several of those employees were no longer employed. She indicated a current employee was certified to train in CPR and First Aid, so they could get caught up.		2-03-12DHS/Designee will perform audits of the daily work assignment to ensure at least one person a shift is certified in CPR/First Aid 5 x week x one month then 3 x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 2-03-12	

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R0120	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff who had contact with residents were provided 6	R0120	R 120No residents suffered ill effects from the alleged deficient practice.Completion Date 2-03-12All residents have the	02/03/2012

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	hours of dementia-specific training within 6 months, for 3 of 11 employees reviewed for dementia training. (CNA #3, Housekeeper #1, CNA #4) Finding includes: The facility dementia training records were provided by the Legacy Neighborhood Director on 12/30/11 at 11:30 a.m. and reviewed at that time. Review of the records included, but were not limited to the following: -CNA #3's record indicated she was hired 3/2/11. Her dementia training was provided 10/17/11. Records indicated she worked on the Legacy Unit, an Alzheimer's dementia care unit. -Environmental Services Assistant #1's record indicated she was hired 12/14/10. Her dementia training was provided 8/16/11. -CNA #4's record indicated she was hired 12/14/10. Her dementia training was provided 10/17/11. The Administrator indicated during interview on 12/30/11 at 12:40 p.m., they were behind on some dementia training.		potential to be affected by the alleged deficient practice and through changes in provision of care and in inservicing will prevent the recurrence of the deficient practice.Completion Date 2-03-12In services were completed for dementia training. Systemic change includes campus to have one 6 hour dementia training class a month and legacy director to keep a tickler file of all employees and dementia training dates with dates of hire.Completion Date 2-03-12Legacy Coordinator / Designee will perform audit of tickler file weekly to assure in compliance with training regulations with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 2-03-12	

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R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure tuberculin skin tests were completed timely, for 3 of 7 sampled residents, in that they were not completed on admission and/or not completed annually. (Residents #86, #72, #82) Findings Include: 1. The clinical record for Resident #86 was reviewed on 12/30/11 at 10:15 a.m. The record indicated the resident was admitted to the facility on 6/29/11. Resident #86 was given a first step tuberculin skin test on 7/1/11 and a	R0410	R 410Resident #86, 72 and 82 PPD are now current.Completion Date 2-03-12All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure tuberculin skin tests are completed timely.Completion Date 2-03-12Nursing staff will be in serviced on timely administration of tuberculin skin test.Systemic change will be a calendar tickler utilized to assure tuberculin skin test are administered timely.Completion Date 2-03-12DHS/Designee will monitor residents to assure tuberculin skin test given timely on 2 random resident's daily x 5	02/03/2012

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	second step tuberculin skin test on 7/14/11. In an interview on 1/3/12 at 9:30 a.m., the Director of Nursing [DoN] indicated the first step tuberculin skin test on Resident #86 was not given on or prior to admission. She stated, "I checked into it. It was given late." 2. Resident #72's clinical record was reviewed on 1/3/12 at 9:25 a.m. The resident was admitted to the facility on 11/22/10. The last recorded Mantoux skin test for tuberculosis was dated 12/5/10. 3. The clinical record of Resident #82 was reviewed on 1/4/12 at 12:15 p.m.. Resident #82 had a physician's order, dated 9/16/11, for a PPD [Mantoux-TB test]. There was no documentation the PPD was given. Upon interview of the Administrator on 1/4/12 at 3:00 p.m., it was determined that Resident #82 had PPD ordered on 9/16/11 but had never received the PPD. On 1/4/12 at 10:05 a.m., a document provided by the [DoN] titled "Guidelines for TB Results Summary Documentation: Residents" indicated the policy of this facility is upon admission each resident shall receive a two step tuberculin skin test to ensure they are free of tuberculosis.		days, 3 x week for 2 weeks, than weekly with results of compliance being forwarded to QA committee monthly x 6 months for review and further suggestions/comments.Completion Date 2-03-12	

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	The policy also indicated the following: "An order should be written upon admission to re-test annually to ensure each resident is re-tested on their admission anniversary date with a one-step Mantoux...."			